Medical Policy

Medically Necessary Hospital Services for Non-Covered Dental Services

Policy Number: OCA 3.723
Version Number: 8
Version Effective Date: 05/08/17

Product Applicability

<table>
<thead>
<tr>
<th>Well Sense Health Plan</th>
<th>Boston Medical Center HealthNet Plan</th>
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</thead>
<tbody>
<tr>
<td>✗ New Hampshire Medicaid</td>
<td></td>
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<tr>
<td>✗ NH Health Protection Program</td>
<td></td>
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<tr>
<td>✗ MassHealth</td>
<td></td>
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<tr>
<td>✗ Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
<td></td>
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<tr>
<td>✗ Senior Care Options ◊</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan covers facility and other related charges for non-covered dental services when admission to a network hospital, a surgical day care unit, or to an ambulatory surgical facility is medically necessary in order to receive non-covered dental services due to a serious non-dental medical condition. Prior authorization is required. The service must be covered for the Plan member, as specified in the member’s applicable benefit document available at www.bmc hp.org for a member enrolled in a BMC HealthNet Plan product, at www.SeniorsGetMore.org for a Senior Care Options member, or at www.wellsense.org for a member enrolled in a Well Sense Health Plan product.

Medically Necessary Hospital Services for Non-Covered Dental Services

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It will be determined during the Plan’s prior authorization process if the service is considered medically necessary for the requested indication. See the Plan’s policy, *Medically Necessary* (policy number OCA 3.14), for the product-specific definitions of medically necessary treatment.

**Description of Item or Service**

**Medically Necessary Hospital Services for Non-Covered Dental Services:** Dental services provided in a hospital, surgical day care unit, or ambulatory surgical center due to a serious non-dental medical condition.

**Medical Policy Statement**

The Plan considers hospital services related to non-covered dental services to be medically necessary when ALL of the following Plan criteria are met and documented in the member’s medical record, as specified below in items 1 through 3:

1. Condition requires medically necessary treatment at a medical facility, as determined by the treating provider; AND

2. The hospital service is normally a covered service for the member and is provided at a network facility (i.e., network hospital, surgical day care unit, or ambulatory surgical facility); AND

3. Member has a serious and non-dental medical condition that includes but is not limited to at least ONE (1) of the following, as specified below in items a through l:
   
   a. History of bleeding disorder or blood dyscrasia such as hemophilia and clotting disorders; OR

   b. History of adverse reaction to anesthesia or sedation or when local anesthesia is ineffective due to acute infection, allergy, or anatomical variation; OR

   c. Evidence of acute cardiac disease, angina, class III or IV CHF, or an MI within 90 calendar days of the anticipated admission; OR

   d. History of severe immunodeficiency disease with extreme susceptibility to bacteremia, septicemia, and/or sepsis (as determined and documented by the treating provider); OR

   e. History of or familial risk for malignant hyperthermia; OR

   f. Abnormal pulmonary function measurements (i.e., FEV1 < 60% of predicted); OR

   g. Poorly controlled endocrine disorders (e.g., diabetes, Addison’s disease), hypertension, bronchospastic lung disease, or seizures; OR

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h. History of clinically severe obesity with obstructive sleep apnea, with clinically severe obesity defined as a body mass index (BMI) \( \geq 40 \text{ kg/m}^2 \) or a BMI \( \geq 35 \text{ kg/m}^2 \) when accompanied by a comorbid condition; OR

i. High-risk pregnancy prohibiting safe care in an office setting; OR

j. High-risk pediatric patient including those with cardiopulmonary congenital defects, diabetes, asthma, sleep apnea, and/or bleeding disorders prohibiting safe care in an office setting; OR

k. Significant physical, behavioral, or developmental functional impairment (i.e., extremely uncooperative, unmanageable, anxious or uncommunicative) inhibiting safe care in an office setting; OR

l. Previous attempts to provide care in an office setting have been unsuccessful.

**Limitations**

The Plan does NOT cover non-emergent dental services. See Plan’s applicable reimbursement policies available at [www.bmchp.org](http://www.bmchp.org) for BMC HealthNet Plan members and [www.wellsense.org](http://www.wellsense.org) for Well Sense Health Plan members.

**Definitions**

**Body Mass Index (BMI):** Body mass index describes relative weight for height and correlates with total fat content. BMI is calculated as weight (kg)/height squared (m\(^2\)). The classification of BMI is specified in the table below. To estimate BMI using pounds and inches, use the following formula: Weight (pounds)/height (inches) x 703.

<table>
<thead>
<tr>
<th>Description</th>
<th>Classification</th>
<th>BMI (kg/m(^2))</th>
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</thead>
<tbody>
<tr>
<td>Underweight</td>
<td></td>
<td>&lt;18.5</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td>18.5-24.0</td>
</tr>
<tr>
<td>Overweight</td>
<td></td>
<td>25.0-29.9</td>
</tr>
<tr>
<td>Obesity</td>
<td>I</td>
<td>30.0-34.9</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>35.0-39.9</td>
</tr>
<tr>
<td>Extreme Obesity</td>
<td>III</td>
<td>( \geq 40 )</td>
</tr>
<tr>
<td>Super Obesity</td>
<td></td>
<td>( &gt;50 )</td>
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<tr>
<td>Super Super Obesity</td>
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<td>( &gt;60 )</td>
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Clinically Severe Obesity (Morbid Obesity): A disease of excess energy stores in the form of fat. Clinically severe obesity correlates with a body mass index (BMI) of greater than or equal to 40 kg/m² or a BMI of greater than or equal to 35 kg/m² accompanied by comorbid conditions that include but are not limited to: coronary artery disease, clinically refractory hypertension, severe obstructive sleep apnea, type 2 diabetes, Pickwickian syndrome, obesity related cardiomyopathy, and/or pulmonary hypertension.

Malignant Hyperthermia (MH): A complex genetic disorder that typically manifests clinically as a hypermetabolic crisis when a susceptible individual receives certain anesthetic triggering agents. Patients who are susceptible to MH have skeletal muscle receptor abnormalities with symptoms that include a combination of hypercarbia, muscle rigidity, tachycardia, hyperthermia, metabolic acidosis, and rhabdomyolysis during or shortly after anesthesia. Very little is known about the specific mechanisms by which anesthetics interact with these abnormal receptors to trigger an MH crisis. Avoidance of anesthetic triggers in MH susceptible patients and prompt administration of dantrolene when an acute event occurs have significantly reduced the mortality associated with malignant hyperthermia. The prevalence of susceptibility to MH in the general population is unknown, but it is estimated at 1:2000 by the Malignant Hyperthermia Association of the United States; approximately half of the cases are from an inherited autosomal genetic variance and the remaining cases are presumed to be new mutations.

Applicable Coding

See the applicable Plan reimbursement policies available at [www.bmchp.org](http://www.bmchp.org) for the coding guidelines for medically necessary services rendered to a Plan member enrolled in a BMC HealthNet Plan product or a Senior Care Options product. Review the applicable Plan reimbursement policies at [www.wellsense.org](http://www.wellsense.org) for the coding guidelines of medically necessary services provided to a Well Sense Health Plan member.

Clinical Background Information

At the time of the Plan’s most recent policy review, no clinical guidelines were found from the Centers for Medicare & Medicaid Services (CMS) for medically necessary hospital services for non-covered dental services (i.e., dental services provided in a hospital, surgical day care unit, or ambulatory surgical center due to a serious non-dental medical condition). Determine if applicable CMS criteria are in effect for the specified service and the indication for treatment in a national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request for a Senior Care Options member.
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References


<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
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<tr>
<td>Regulatory Approval: N/A</td>
<td>01/01/12 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)</td>
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<td>06/29/11: MPCTAC</td>
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<td>07/27/11: QIC</td>
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*Effective Date for the BMC HealthNet Plan MassHealth Product(s): 08/01/15
*Effective Date for the Well Sense Health Plan Product(s): 08/01/15
*Effective Date for the Senior Care Options Product(s): 01/01/16

<table>
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<tr>
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<th>Revision Effective Date and Version Number</th>
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<tr>
<td>06/01/12</td>
<td>No changes.</td>
<td>Version 2</td>
<td>06/20/12: MPCTAC 07/25/12: QIC</td>
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<td>05/01/13</td>
<td>Review for effective date 09/01/13. Updated Summary and Description of Item or Service sections. Revised Medical Policy Statement section. Revised language in Applicable Coding sections. Referenced applicable Plan policies.</td>
<td>09/01/13 Version 3</td>
<td>05/15/13: MPCTAC 06/20/13: QIC</td>
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<td>04/01/14</td>
<td>Review for effective date 08/01/14. Revised Medical Policy Statement section and Definitions section to include a definition of BMI and morbid obesity.</td>
<td>08/01/14 Version 4</td>
<td>04/16/14: MPCTAC 05/14/14: QIC</td>
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<td>04/01/15</td>
<td>Review for effective date 08/01/15. Updated References section. Updated policy template. Changed the term “morbid obesity” to “clinically severe obesity” without revising criteria in the Medical Policy Statement section. Updated Summary section. Added MassHealth and the Well Sense Health Plan products as applicable for this policy and will require prior authorization for this service. Administrative changes made to the Limitations and Applicable Coding sections.</td>
<td>08/01/15 Version 5</td>
<td>04/15/15: MPCTAC 05/13/15: QIC</td>
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<td>11/01/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and notes. Updated Summary section.</td>
<td>01/01/16 Version 6</td>
<td>11/18/15: MPCTAC 12/09/15: QIC</td>
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<td>Review for effective date 08/01/16. Updated Definitions, Applicable Coding, Clinical Background Information, and</td>
<td>08/01/16 Version 7</td>
<td>04/20/16: MPCTAC 05/23/16: QIC</td>
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Policy Revisions History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<th>Version</th>
<th>Authorizing Entity</th>
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<tr>
<td>04/01/17</td>
<td>Review for effective date 05/08/17. Updated References section.</td>
<td>05/08/17</td>
<td>Version 8</td>
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Last Review Date

04/01/17

Next Review Date

04/01/18

Authorizing Entity

MPCTAC

Other Applicable Policies

Medical Policy - Medically Necessary, policy number OCA 3.14
Reimbursement Policy - Dental Services, policy number 4.15
Reimbursement Policy - General Billing and Coding Guidelines, policy number 4.31
Reimbursement Policy - General Billing and Coding Guidelines, policy number WS 4.17
Reimbursement Policy - General Clinical Editing and Payment Accuracy Review Guidelines, policy number 4.108
Reimbursement Policy - General Clinical Editing and Payment Accuracy Review Guidelines, policy number WS 4.18
Reimbursement Policy - Inpatient Hospital, policy number 4.110
Reimbursement Policy - Oral Surgery, policy number WS 4.34
Reimbursement Policy - Outpatient Hospital, policy number 4.17
Reimbursement Policy - Physician and Non Physician Practitioner Services, policy number 4.608
Reimbursement Policy - Physician and Non Physician Practitioner Services, policy number WS 4.28
Reimbursement Policy - Professional Bilateral and Multiple Procedure Reductions, policy number: WS 4.24
Reference to Applicable Laws and Regulations


Disclaimer Information:

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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